No. 88-2043

In The

Supreme Court of the United States

October Term, 1989

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF PETITIONERS

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QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a state.

PARTIES TO THE PROCEEDINGS

Appellants in the Court of Appeals and defendants in the District Court are the Governor and the Secretary of Health and Human Resources of the Commonwealth, as well as the Director of the Department of Medical Assistance Services and members of the Virginia Board of Medical Assistance Services. Although the Governor and Secretary initially were sued in their individual capacities, they were dismissed in such capacities by consent of the plaintiff and by order of the District Court on May 2, 1986. They are now sued only in their official capacities.

Appellee, in the Court of Appeals and plaintiff in the District Court is the Virginia Hospital Association ("VHA"), a non-profit organization whose members include Virginia hospitals.

In the Court of Appeals, twenty-seven states filed or joined an amicus brief in support of the Commonwealth on the issue herein. The American Hospital Association filed an amicus brief in support of the VHA on the same issue. Thirty-seven states joined in an amicus brief urging this Court to hear this appeal.

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

Pages

CASES

TABLE OF AUTHORITIES – Continued

Pages

TABLE OF AUTHORITIES – Continued

FEDERAL STATUTES

STATE STATUTES

TABLE OF AUTHORITIES – Continued

FEDERAL REGULATIONS

MISCELLANEOUS

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BRIEF OF PETITIONERS

On June 15, 1989, the Commonwealth of Virginia ("the Commonwealth") whose officials were Appellants below, filed a Petition for Writ of Certiorari ("the Petition") seeking review of the judgment of the United States Court of Appeals for the Fourth Circuit in this matter. On October 2, 1989, the Court granted a Writ.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, dated February 22, 1989, is reported at 868 F.2d 653 and is also set forth in Appendix A to the Petition. The March 22, 1989 order of the Court of Appeals denying the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc* is set forth in Appendix B to the Petition. The March 29, 1989 order of the Court of Appeals denying a stay of its mandate is set forth in Appendix C to the Petition.

The order and opinion of the United States District Court for the Eastern Division of Virginia, Richmond division, dated May 18, 1988, are unreported and are set forth in Appendix D to the Petition.

Citations herein are to the Appendices to the Petition ("App.") or the Joint Appendix ("J.A.").

JURISDICTION

The jurisdiction of this Court to issue a writ of certiorari in this case is grounded upon 28 U.S.C. § 1254(1).

STATUTES INVOLVED

VHA has brought suit pursuant to 42 U.S.C. § 1983, which states:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceedings for redress.

This appeal raises the question whether Medicaid providers may bring suit against the states in federal court under § 1983. The answer to this question turns upon the construction and application of a number of provisions of Title XIX of the Social Security Act (42 U.S.C. §§ 1396-1396t) ("the Medicaid Act"). The most important is 42 U.S.C. § 1396a(a)(13)(A), Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, § 2173(a), 95 Stat. 808 ("the Boren Amendment"), which reads, in pertinent part, as follows:

> A state plan for medical assistance must . . . provide . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access. . . .

42 C.F.R. §§ 447.250-447.280 sets forth the regulations implementing the Medicaid Act. The final rules implementing the Boren Amendment were published in 48 Fed. Reg. 56046-56059 (1983); *See also* 42 C.F.R. § 447.253(b).

STATEMENT OF THE CASE

1.

Procedural Background

On March 19, 1986, VHA filed this suit in the United States District Court for the Eastern District of Virginia challenging the validity of payment rates for hospitals participating in the Commonwealth's Medicaid program, which is administered by the Virginia Department of Medical Assistance Services ("DMAS") pursuant to Chapter 10, Title 32.1 (§§ 32.1-323-32.1-330) of the Code of Virginia. The complaint challenged the validity of the mechanism ("Prospective Payment System") used by DMAS in setting prospective *per diem* rates for inpatient hospital care of Medicaid patients, as well as the validity of the regulations prescribing procedures for the filing and processing of appeals ("Appeals System") by hospitals not satisfied with their prospective rates.

On September 22, 1986, the District Court dismissed the complaint. It ruled that VHA, being in privity with one of its member hospitals which had been a plaintiff in earlier litigation in the same court on the same subject, was collaterally estopped from bringing this action by reason of the earlier unfavorable ruling in *Mary Washington Hospital v. Fisher,* 635 F.Supp. 891 (E.D.Va. 1985).

On appeal, the Court of Appeals reversed. *Virginia Hospital Association v. Baliles,* 830 F.2d 1308 (4th Cir. 1987). It ruled that VHA, a trade association suing on behalf of its member hospitals and others, was not so estopped.

On remand, the Commonwealth moved to dismiss on eight grounds. The District Court denied the motion, but

on May 18, 1988, certified those eight issues to the Court of Appeals for interlocutory appeal. The Court of Appeals on July 27, 1988, granted that appeal. On February 22, 1989, it affirmed the ruling of the District Court, holding, *inter alia,* that the Boren Amendment confers "an enforceable right on providers" because it "guarantees reasonable and adequate reimbursement to hospitals that achieve cost-efficiency," and it does not create a "remedial scheme so comprehensive as to foreclose a private judicial remedy." (App. at A-9 to A-12). On March 22, 1989, the Court of Appeals denied the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc.* On March 29, 1989, it denied a stay of its mandate pending the filing of the Petition.

This Court granted a Writ of Certiorari to consider one issue – whether a Medicaid provider has a private federal cause of action under § 1983 to enforce the Medicaid Act against a state.[1]

2.

Factual Background

The Commonwealth, like all states, participates in the national Medicaid program pursuant to the Medicaid Act.

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[1] This Court agreed to decide this same issue in 1987, but it did not address the merits because of changes in the underlying facts that rendered the case then under review moot. *Coos Bay Care Center v. Oregon Department of Human Resources,* 803 F.2d 1060, (9th Cir. 1986), *cert. granted,* 107 S.Ct. 1970 (1987), *judgment vacated and remanded on the issue of mootness,* 108 S.Ct. 52 (1987).

As noted above, DMAS is the agency of the Commonwealth that has been charged since 1985 with the responsibility for administering that program in Virginia. Under the program, DMAS has promulgated implementing regulations known collectively as the State Plan.

Until 1981, the Medicaid Act required states to pay participating hospitals the "reasonable cost" of inpatient services to Medicaid patients. In 1982, in response to the Boren Amendment, the Commonwealth adopted the Prospective Payment System as an amendment to the State Plan to allow the use of prospective payment for hospital services, effective July 1, 1982. (J.A. 24-45). Under the Prospective Payment System, cost medians from 1981 data were used as a starting point and an inflator, a modified Consumer Price Index ("CPI"), was used to inflate such medians to determine payment levels for subsequent years. (J.A. 12-13 and 26).

In 1983, one of VHA's member hospitals brought a challenge to the Prospective Payment System. *Mary Washington Hospital, supra*. On January 4, 1985, the District Court in *Mary Washington* – the same District Court as in this case – upheld the legality of the Prospective Payment System in its entirety, except for its distinct appeals mechanism, but ordered the Commonwealth to promulgate a new appeals mechanism. The new Appeals System was adopted by DMAS in August 1985, and approved by the federal Health Care Financing Administration ("HCFA") on March 3, 1986. (*See* J.A. 32-45). The District Court upheld the legality of the Appeals System by order dated April 21, 1986. No appeal was filed.

With the exception of three replacements of the CPI with different inflators and other minor changes not relevant to this litigation, the Prospective Payment System remains unchanged since its original promulgation in 1982. The Appeals System has not been amended at all since its 1985 promulgation. None of the almost 100 member hospitals of VHA represented in this litigation has pursued an appeal under the Appeals System, although they have preserved their right to do so.[2]

SUMMARY OF ARGUMENT

The intent of Congress is the key to determining whether hospital providers have an implied right of action under § 1983 to enforce the Boren Amendment against the states in federal court. *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 377, (1982); *Middlesex County Sewerage Auth'y v. National Sea Clammers Ass'n*, 453 U.S. 1, 13 (1981). *See also Cannon v. University of Chicago*, 441 U.S. 677, 740 (1979) (Powell, J. dissenting). Whether judged under the "benefited class" analysis, first set forth in *Cort v. Ash*, 422 U.S. 66 (1975) and modified by *Cannon, supra*, and *Merrill Lynch, supra*, or the

[2] The lower courts have ruled that VHA has standing to bring this action on behalf of its members (App. at A-14), even though it is not a hospital or a Medicaid provider and has no direct or proprietary interest in its members' reimbursement. 830 F.2d at 1312-13.

"enforceable rights" analysis of *Maine v. Thiboutot*, 448 U.S. 1 (1980) and its progeny, the fundamental question in determining congressional intent is the same: at the time the Boren Amendment passed in 1981, did Congress know that its failure to provide an express right of action for providers would be construed to mean that a federal cause of action to enforce the Boren Amendment would be implied under § 1983? *Merrill Lynch*, 456 U.S. at 378-79.

Several factors are relevant in deciding the answer to this question. The first is whether the language of the Boren Amendment is "right- or duty-creating language" that "explicitly conferred a right directly on a class of persons" including hospital providers of medical services to Medicaid-eligible patients. *Cannon*, 441 U.S. at 690, n.13. The Boren Amendment explicitly imposed on the states general standards to be met in establishing new prospective payment systems designed to control Medicaid costs while assuring the continued availability of medical services for the needy. The language of the Boren Amendment, however, does not reveal an "unmistakable focus" on providers as the "benefited class." *Cannon*, 441 U.S. at 691. It does not create an enforceable right by affirmatively granting providers a "right" to any level of payment if they contract to provide services under the Medicaid program.

The second factor in determining Congressional intent is whether an implied right of action for providers under § 1983 was a part of the "contemporary legal context" of 1981 when Congress passed the Boren

Amendment. *See Merrill Lynch*, 456 U.S. at 381. At the time Congress adopted the Boren Amendment, both the general implied right and § 1983 lines of cases had evolved from the early reflexive analysis that almost always assumed the existence of implied federal rights of action, *see, e.g., Texas & Pacific R. Co. v. Rigsby*, 242 U.S. 33 (1916), to the more considered calculus of *Cort, supra, Cannon, supra* and *Sea Clammers, supra*. Congress is assumed to have had knowledge of these developments when it acted. *Cannon*, 441 U.S. at 696-97. Thus, its failure to grant providers an explicit right of action to enforce the Boren Amendment weighs heavily against the implication of private rights by the Court.

Moreover, the elaborate federal/state partnership embodied in the Medicaid Act evidences Congressional intent to foreclose, rather than to grant, federal causes of action by providers against the states. Under the Medicaid Act, the states have extensive administrative responsibility for the operation of the program. The program, as developed, reflects an elaborate series of checks and balances designed to assure the delivery of necessary medical services to the needy, while leaving the states flexibility in designing payment systems and giving the federal government sufficient control to assure fiscal accountability. The comprehensiveness of the scheme, the existence of federally mandated state administrative appeals procedures and the adoption and repeal of a required waiver of the states' Eleventh Amendment immunity, all confirm Congress' intent to limit provider payment challenges to state administrative procedures and appropriate judicial review by state courts.

The validity of this reading of Congressional intent is confirmed by the administrative interpretation of the Boren Amendment reflected in regulations adopted contemporaneously by the federal official charged with the responsibility to administer the Medicaid program, 48 Fed. Reg. 56046, 56052 (1983). The Secretary of Health and Human Services explicitly declined to adopt regulations requiring the states to permit providers to challenge payment decisions in judicial forums. The Secretary determined that such challenges should be reviewed in state administrative proceedings, not federal courts. This interpretation should be accorded "considerable weight" by this Court in deciding the implied rights question. *Chevron, USA, Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

ARGUMENT

I.

CONGRESS DID NOT INTEND HOSPITAL PROVIDERS TO HAVE AN IMPLIED CAUSE OF ACTION TO ENFORCE THE MEDICAID ACT UNDER § 1983

Two lines of cases leading to implied private rights of action increasingly are merged in the opinions of this Court. The first line of cases, governing the general question whether a federal statute includes a private right of action, extends over several generations from *Rigsby, supra* through *Cort, supra* and *Merrill Lynch, supra*. The historical evolution of this line of cases, summarized in

Merrill Lynch, 456 U.S. at 374-377, demonstrates that this Court no longer will imply a private cause of action solely from the fact that a particular federal statute was enacted for the benefit of a special class, as the Court did in *Rigsby, supra*. Rather than assume a judicial remedy for the benefited class from Congressional silence or ambiguity, the Court now focuses specifically on the question whether Congress *intended* to create a private *remedy* for the benefited class. *Merrill Lynch*, 456 U.S. at 378-79.

Similarly, the implied right of action cases under § 1983 increasingly look to legislative intent to create a cause of action as the dispositive factor in determining whether § 1983 is available to enforce a violation of a federal statute against a state. Thus, even where a federal statute is intended to benefit a defined class of persons or entities, unless *Congress* also intended to create "enforceable rights" for that defined class, no cause of action under § 1983 can be implied. *Wright v. Roanoke Redevelopment & Housing Auth'y*, 479 U.S. 418, 423 (1987). Moreover, even where such enforceable rights are express or implied, the existence of a comprehensive alternative enforcement scheme to vindicate those rights will be read as evidence of a Congressional intent to foreclose an implied right of action under § 1983. *Sea Clammers*, 453 U.S. at 19-20.

Accordingly, no private cause of action on behalf of hospital providers should be implied under § 1983 in this case unless this Court determines that Congress specifically *intended* hospital providers to be able to pursue

payment disputes under the Medicaid program directly in federal court.[3] Congressional intent to create such a cause of action should not be implied based on the nature of the Medicaid program or the status of providers, but rather should be found, if at all, only in explicit rights-granting language not accompanied by the existence of an alternative enforcement mechanism.[4]

A. The Language of the Boren Amendment to the Medicaid Act Does Not Confer "Enforceable Rights" on Hospital Providers.

The language of the Boren Amendment cannot fairly be read to create rights or duties. Section 1396a(a)(13)(A)

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[3] Neither VHA nor the lower courts have even suggested that the Medicaid Act creates an express right enforceable by a Medicaid provider against a state. (App. at A-5). The statute is silent, a fact which, when combined with a correct analysis of its actual language, of its purpose and of its legislative history, leads to the inescapable conclusion that Congress did not simply overlook the issue. It made deliberate choices about how the Medicaid program should work.

[4] As this Court most recently recognized in *Dellmuth v. Muth*, ___ U.S. ___, 109 S.Ct. 2397 (1989) and *Will v. Michigan*, ___ U.S. ___, 109 S.Ct. 2304 (1989), courts should not attempt to imply the fundamental realignment of powers allocated to the state and federal systems without a clear expression of congressional intent, manifest in the statute under review. To allow providers to challenge state reimbursement systems in federal court would have just such an effect, without any indication of Congress' intent to provide a federal cause of action. Furthermore, such a result would promote none of the goals normally inherent in federal litigation over federal statutes as each state's reimbursement system is unique and tailored to the special health care cost conditions in the particular state.

merely authorizes the states to devise payment rates which *the state finds, and makes assurances satisfactory to the Secretary, are "reasonable and adequate"* to meet the cost which "must be incurred by efficiently and economically operated facilities" to provide patient care. The statute allows the rates to be set in accordance with methods and standards developed by each state, reviewable only by HCFA.

This broad standard of "reasonable and adequate" is not the kind of language Congress has used to create an enforceable right. It does not read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C.Cir. 1987). Rather than "right- or duty-creating language," *Cannon*, 441 U.S. at 690 n.13, the relevant language in the Medicaid Act is very much analogous to that examined by this Court in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), and it is quite different from the specific and objective standards found to exist in *Wright, supra*.[5]

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[5] The Court of Appeals acknowledged (App. at A-6, n.3) that the Medicaid Act was enacted under the spending power of Article I, Section 8, clause 1 of the United States Constitution. The Court in *Pennhurst* likened such legislation to a contract. In this case, the contracting parties are the federal and state governments. "The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the 'contract' . . . . There can, of course, be no knowing acceptance if a state is unaware of the conditions or is unable to ascertain what is expected of it." 451 U.S. at 17. (Citations omitted). The Court of Appeals, nevertheless, proceeded unilaterally to rewrite that contract to the detriment of the states.

In *Pennhurst*, an action was brought under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000-6081, *et seq.*, to challenge conditions at a state facility for the mentally retarded. One part of the statute, § 6010, the "bill-of-rights" provision relied on by the plaintiffs, set out a series of findings respecting the rights of persons with developmental disabilities. Plaintiffs also alleged a violation of § 6011 which required participating states, as a condition of receiving federal funds, to make "assurances" to the Secretary about their plans for retarded citizens.

This Court held that § 6010 does not create substantive rights and does no more than express a Congressional preference for certain kinds or treatment. 451 U.S. at 11, 19. It found the statutory language precatory, not mandatory. On the section governing "assurances," the Court stated that "[i]t is at least an open question whether an individual's interest in having a state provide these 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28.

In *Wright*, tenants in a federally funded housing project sued to enjoin violations of a rent ceiling imposed by the Brooke Amendment to the Housing Act of 1937, P.L. 91-152, § 213, 83 Stat. 389. There the Court found that the statute "could not be clearer" in setting a mandatory and numerically specific limitation on rents. 479 U.S. at 430. The Court reviewed the statute and implementing HUD regulations and determined that the benefits Congress intended to confer on *tenants* are sufficiently specific and definite to qualify as enforceable under § 1983. 479 U.S. at 432.

The Boren Amendment obviously enunciates a policy goal or choice of Congress, reviewable by HCFA, but leaves the states considerable flexibility in the achievement of that goal. That being so, it is not the kind of statute that imposes – beyond the submission of assurances to HCFA – an affirmative obligation, *Polchowski v. Gorris*, 714 F.2d 749, 751 (7th Cir. 1983), or is "cast in the imperative." *Alexander v. Polk*, 750 F.2d 250, 259 (3d Cir. 1984).

The lower courts in this case have ruled that hospitals *are* among the intended beneficiaries of the Medicaid program, a national joint federal/state welfare program designed to pay medical expenses for the eligible poor, and therefore, that they have "enforceable rights" under the Boren Amendment. For a rationale, the Court of Appeals merely looked at a large number of provisions of the Medicaid Act (App. at A-7) which spell out what a state plan must contain. Because that statute – one of the most complex in existence[6] – gives detailed instructions to the federal Secretary (HCFA) regarding conditions for continued approval of state plans, the Court of Appeals made the conclusory and wholly unsupported assumption that these conditions are all necessarily enforceable by *providers* under § 1983.[7] In so doing, the Court of

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[6] This Court has called the Medicaid Act "Byzantine." *See, Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

[7] While two other circuits have followed the lead of the Court of Appeals in this case, federal courts are far from unanimous on the correct resolution of the issue of implied provider rights now before this Court. *Compare West Virginia University Hospitals, Inc. v. Casey*, No. 89-5165 (3d Cir. September 5, 1989) and *Amisub (PSL), Inc. v. Colorado Department of*

(Continued on following page)

Appeals equated the receipt of some financial benefit from participation in the Medicaid program with an enforceable right to a particular level of payment. One does not follow from the other.[8]

Moreover, the equation drawn by the Court of Appeals ignores the purpose of the statutes involved and misapplies *Pennhurst* and *Wright*. The elaborate statutory requirements of the Medicaid Act are nothing more than

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(Continued from previous page)

Social Services, 879 F.2d 789 (10th Cir. 1989), (accepting the Fourth Circuit's reasoning) *with Silver v. Baggiano*, 804 F.2d 1211, 1216 n.3 (11th Cir. 1986); *Green v. Cashman*, 605 F.2d 945 (6th Cir. 1979); and *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975) (health care provider is not the intended beneficiary of the Medicaid program). The Tenth Circuit's pre-*Amisub* decisions conflict. *Compare Colorado Health Care Ass'n v. Colorado Department of Social Services*, 842 F.2d 1158 (10th Cir. 1988) *with Geriatrics, Inc. v. Harris*, 640 F.2d 262 (10th Cir. 1981), *cert. den.* 454 U.S. 832 (1981). *See generally Cervoni v. Secretary of Health, Education and Welfare*, 581 F.2d 1010 (1st Cir. 1978) (holding that a physician is not the intended beneficiary of the Medicare program).

[8] *Pennhurst* holds that a statute may benefit a class without being directly enforceable by those beneficiaries. By glossing over the difference between providers and recipients and by assuming providers are intended beneficiaries of the Medicaid Act, the Court of Appeals concluded that there must, of necessity, be private § 1983 enforcement. As a result, it performed no principled analysis as to whether providers truly are the intended beneficiaries and whether increased reimbursement for providers would necessarily and directly result in improved access to or quality of health care for recipients. Because there are competing interests at stake, this approach was not sufficient.

a checklist of grant conditions.[9] Each represents a Congressional instruction for HCFA to use in reviewing state plans. In fact, each change in state plan requirements generates a response from HCFA in the form of revised instructions to the participating states. HCFA has even developed an instruction manual for the states and a large number of "pre-printed" pages to be checked off and included in state plans. Failure to comply can, and sometimes does, result in disallowance of federal funding. Such disputes, because they involve a *federal* agency, are necessarily resolved through federal administrative and judicial review. There is not the slightest indication, however, that Congress intended the burgeoning provisions of the Medicaid Act to be enforceable privately against *states* by Medicaid providers in federal court.

B. No Intent to Create an Implied Right of Action Can Be Inferred from the Legislative History of the Boren Amendment or the Medicaid Act.

The original and sole continuing purpose of the Medicaid Act is to create a program which is designed to pay

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[9] Participation in the Medicaid program is voluntary, except as to those providers who have contracted to participate for other reasons, such as the valuable consideration received under the Hill-Burton program. 42 U.S.C. §§ 291-291o-1. Thus, a provider has a right to reimbursement as provided by the mutual obligations of a contract with its respective state. Such contracts, voluntarily renewed on a regular basis, obligate the providers to accept as payment in full the payments provided pursuant to the state regulations challenged by the VHA in this litigation.

for medical care for the eligible poor.[10] Nothing in the legislative history of the Act contains even a suggestion that Congress intended providers to be its beneficiaries or to have privately enforceable rights.[11] To the contrary, the legislative record shows conclusively that the growing and increasingly complex provisions of the Medicaid Act – and in particular the Boren Amendment – are designed to guide HCFA in its continuous oversight and review of state plans and programs.

A correct reading of the Boren Amendment and the underlying regulations, 42 C.F.R. §§ 447.250-447.280, demonstrates that Congress intended the various states' implementing programs to be policed and reviewed *by the Secretary*, not through a myriad of private actions in federal courts. The Medicaid Act was intended to require the participating states to provide assurances to the

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[10] The purpose of the Medicaid Act is:

> For the purpose of enabling each State as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care . . . .

42 U.S.C. § 1396.

[11] *See generally* S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943.

Secretary of the reasonableness of payment rates and to obtain the Secretary's approval as a pre-condition to federal funding.

From 1972 until 1981, Congress had required "reasonable cost" reimbursement to be paid by the states to hospital and nursing home providers, thus linking such reimbursement to those facilities' actual costs in a way designed to assure that payment would reflect the costs necessary to provide service of adequate quality. *See* S. Rep. 96-471, 96th Cong., 1st Sess. 28 (1979). Under "reasonable cost" reimbursement, providers had been able to recover essentially all of their allowable costs incurred in providing care or services to Medicaid patients.

In 1981, Congress abandoned the "reasonable cost" formula by enacting the Boren Amendment.[12] In so doing, Congress made clear that its action represented a significant change in the federal standard, offering the states an opportunity to effect more stringent cost containment while freeing them from excessive oversight of their payment methodologies. *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984). *See also Mary Washington, supra*, 635 F. Supp. at 894, 899. This

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[12] In 1981, Congress adopted for hospitals the principle it had adopted a year earlier for nursing home providers. The Boren Amendment was drawn from a bill previously reported by the Senate Finance Committee. *See* 126 Cong. Rec. 17885-17886. Explaining that bill, Senator Boren, its patron, stated: "[P]ayment methods adopted by the States will carry a presumption of compliance." *Ibid.* The legislative purpose was designed both to remove the prior cost based reimbursement formula and to reduce excessive federal oversight of provider payment methodologies.

change was designed to give states greater flexibility in attempting to promote efficiency in hospital services and to contain soaring Medicaid costs. *Id.* at 894. *Accord, Mississippi Hospital Ass'n, Inc. v. Heckler*, 701 F.2d 511, 521 (5th Cir. 1983).[13]

Congress made a deliberate decision to give the states this flexibility. Such a dramatic change, rejecting expensive cost-based reimbursement and encouraging both state creativity and a wider range of choices for the states, indicates a clear legislative choice to allow state-specific latitude in determining appropriate methodologies for payments to providers. Congress intended nothing more than to provide legislative guidance to HCFA in evaluating state plans. S. Rep. No. 139, 97th Cong., 2d Sess., *reprinted in* 1981 U.S. Code Cong. & Admin. News 744. No objective standards were set or required. Congress stated that it "did not intend to encourage arbitrary reductions" in rates which would adversely affect patient care; it indicated simply that rates must be "related to" providers' reasonable costs. The Committee report itself refers to these statements as "goals." *Id.* (App. at A-9). Under the *Pennhurst* test, "goals" are not "enforceable rights."

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[13] The legislative history of the Boren Amendment indicates that:

> [i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes *the inflationary nature* of the current cost reimbursement system and intends to give States *greater latitude* in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong. 1st Sess. 293 (1983) (emphasis added).

If more proof of Congressional intent were needed, over a decade ago and *before* the adoption of the Boren Amendment, Congress mandated and, within a year thereafter, repealed a requirement that, as a condition of continued participation in the Medicaid program, states waive their Eleventh Amendment immunity from suits by hospitals over reimbursement. That is the exact subject of this litigation. What is particularly instructive, however, is that Congress *expressly rejected* federal litigation over this subject and at the same time – concerned that providers would not have a forum in which to raise reimbursement issues – directed HCFA to develop a mechanism for the adjudication of such disputes. S. Rep. No. 1240, 94th Cong., 2nd Sess., *reprinted in* 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. What resulted is the present regulation requiring *state* appeals procedures such as the Commonwealth's Appeals System. *See* 42 C.F.R. § 447.253(c).

C. No Intent to Create an Implied Right of Action Can Be Inferred from the "Contemporary Legal Context" in Which Congress Acted When It Adopted the Boren Amendment.

This Court held in *Merrill Lynch*, 456 U.S. 353, 378 (1982), that

> [i]n determining whether a private cause of action is implicit in a federal statutory scheme when the statute is silent on that issue, the initial focus must be on the state of the law at the time the legislation was enacted.

Congress is presumed to have been familiar with judicial decisions implying private rights of action as they existed at the time the Boren Amendment was adopted in 1981. *Cannon*, 441 U.S. at 696-697.

At that time, the law of private rights of action had evolved to the point that it was clear explicit "rights-granting" language was necessary to imply a private cause of action for providers under either the Medicaid Act itself, *Cannon*, 441 U.S. at 690-692, or § 1983, *Maine v. Thiboutot*, 448 U.S. 1 (1980). Congress is presumed to know that fact. *Cannon*, 441 U.S. at 696-697. Moreover, Congress is presumed to have known that the existence in the statute and regulations of a comprehensive enforcement scheme would be construed as evidence of Congressional intent to foreclose private enforcement of the Medicaid Act under § 1983. *Sea Clammers*, 453 U.S. at 20; *Pennhurst*, 451 U.S. at 28.

In this context, the failure of Congress either to grant providers an explicit cause of action or to use language explicitly vesting providers with a right to reimbursement under the Medicaid Act[14] means that Congress did not intend for providers to bring suit in federal court under § 1983 to enforce the terms of the Boren Amendment.

D. The Medicaid Program Is a Complex Federal/State Partnership, Reflecting Decades of Difficult Legislative and Political Compromises and Including Federally Mandated Appeals Procedures, from Which a Congressional Intent to Foreclose a Federal Cause of Action Can Be Implied.

In the present case, the Court of Appeals found that the Commonwealth had not met its burden of showing an

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[14] Unlike the statute at issue in *Cannon*, Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, which

(Continued on following page)

implied intent to foreclose. (App. at A-11). Despite an assumption (which is correct) that HCFA vigorously enforces the Medicaid Act, and despite evidence that, unlike the regulations in *Wright*, the federal agency's interpretation is consistent with that of the Commonwealth, the Court of Appeals retreated from its own prior decision on foreclosure in *Phelps v. Housing Authority of Woodruff*, 742 F.2d 816, 821 (4th Cir. 1984). It simultaneously recognized and discounted the fact that the Commonwealth, as required by federal regulation, has established a comprehensive administrative Appeals System.[15] In ruling as it did, the Court of Appeals turned the Medicaid program on its head.[16]

(Continued from previous page)

provides that "no person" shall be discriminated against in any federally assisted program, the Boren Amendment provided only that a "state plan must . . . provide . . . for payment. . . ." *See* page 3 *supra*.

[15] This system also includes state judicial review in accordance with § 32.1-325.1 of the Code of Virginia and pursuant to the Virginia Administrative Process Act, §§ 9-6.14:1-9-6.14:25 of the Code of Virginia.

[16] The Court of Appeals apparently (App. at A-11) found the lack of a judicial remedy in the statute controlling. But *Wright* does not establish the lack of such a provision as the *sine qua non* for legislative foreclosure. Indeed, the *Wright* majority based its decision on what it found to be a clear, mandatory, objective limitation on rental payments in the statute. It also found the intent to benefit tenants "undeniable." 479 U.S. at 430. *Compare* the dissenting opinion of Justice O'Connor in which she stated that the statutory entitlement found by the majority arose not from the statute or the legislative history but from a regulatory interpretation. 479 U.S. at 434-435.

Medicaid is a unique joint federal/state partnership, one in which the *states* have extensive administrative responsibility. Over the years, a series of choices and decisions have been made in its development. These have been hammered out in the political, not the judicial arena, and have been accepted by the states and the federal government as workable. As noted above, the Boren Amendment was expressly designed to allow flexible state payment policies and decisions, reviewable only by HCFA against the growing patchwork of federal legislative and regulatory guidelines. At the same time, HCFA has protected the federal interests expressed in the Medicaid Act through a comprehensive program of ongoing state plan reviews, audits and – where appropriate – adjustments or disallowances sufficient to ensure accountability for federal funds.[17]

Ironically, in relying in their analyses on Congressional efforts to *reduce* federal oversight of state payment methodologies and decisions, the Court of Appeals and the District Court have thwarted and reversed that objective by grafting federal judicial review onto the program. The result is confusing, wasteful of resources and duplicative. To assume that Congress intended such a

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[17] This oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright* to be insufficient to indicate legislative foreclosure of § 1983 remedies. 479 U.S. at 428.

course is unwarranted and illogical. The States that urged this Court to review this case never foresaw a Medicaid program with the potential for multiple and endless litigation of provider payment issues in *both* federal and state courts. They did not bargain for the expense, the delay, or the need for legal and administrative resources that such litigation entails. Nor did they anticipate that their federally-mandated, carefully-constructed and federally-approved administrative appeals systems would be rendered redundant by providers' decisions to seek *de novo* adjudication of payment disputes in the federal courts.

The lower courts have undone the delicate and sometimes difficult compromises reached through the continuing political process and have forced the states to defend their policy choices repeatedly in federal court.[18]

In so doing, the lower courts have diverted increasingly scarce resources, both federal and state, from

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[18] The history of the present case provides just such an example. As soon as the Mary Washington Hospital's unsuccessful challenge to the Commonwealth's reimbursement system in federal court was complete, the VHA filed the present action in the same federal court. While this case was pending, the Commonwealth was forced to, and successfully did, defend *Vantage Healthcare Corp. v. Virginia Board of Medical Assistance Services*, 684 F.Supp. 1329 (E.D.Va. 1988) (holding that a nursing home provider could not challenge under § 1983 the elimination of an incentive payment). Pennsylvania has similarly been plagued by repeated challenges to various aspects of its Medicaid reimbursement system in federal court. At present, Pennsylvania is defending five separate reimbursement challenges brought at the first instance in federal district court. *See* Appendix B of the Amicus Brief submitted by thirty-seven states in support of the petition.

medical care for the poor to the defense of litigation. This weakens this vital national program which, although increasingly costly, is a mainstay of the welfare "safety net" designed to assist our poorest citizens, including a large number of children and the elderly.

The Court should not allow the lower courts' decisions to stand. If Congress had wished to foster repetitive, unnecessary and expensive litigation of this type, it could and should have done so in unmistakably clear language.[19] It did not, and this Court should not fill that legislative role by allowing providers to subvert the long-standing political process which has developed into the present Medicaid program.[20] Taken as a whole, the Medicaid Act and the implementing regulations are sufficiently comprehensive in scope to support a finding that Congress intended to foreclose alternative remedies.

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[19] In his dissent in *Cannon*, 441 U.S. at 749, Justice Powell suggested that requiring such clarity from Congress would "encourage Congress to confront its obligation to resolve crucial policy questions created by the legislation it enacts."

[20] The Court of Appeals suggests that Congress would not have required hospitals to participate in the Hill-Burton program but "implicitly deny" these same hospitals "an enforceable right to reimbursement rates that meet their costs." App. A-10 n.6. To the contrary, this is exactly what Congress intended when its passed the Boren Amendment repealing required cost-based reimbursement and permitting states to adopt prospective payment plans designed to control costs by forcing hospitals to operate economically and efficiently.

II.

THE SECRETARY HAS DETERMINED THAT THE MEDICAID ACT DOES NOT REQUIRE DIRECT JUDICIAL ENFORCEMENT OF PAYMENT DISPUTES AND THIS INTERPRETATION IS ENTITLED TO DEFERENCE.

The agency charged with enforcing the Medicaid Act has determined that state provider payment decisions are best reviewed in state proceedings and that jurisdiction for such review lies exclusively in state forums. In specifically implementing the Boren Amendment in 1981, HCFA published interim regulations that ultimately became final in December of 1983. *See* 46 Fed. Reg. 47964 (1981) and 48 Fed. Reg. 56046 (1983). In the latter, HCFA set out a preamble which, *inter alia*, rejected public comments suggesting that judicial review of payment rates should be provided:

> [A]bsent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available *in their States* after they have exhausted the administrative appeal process.

48 Fed. Reg. 56046, 56052 (1983) (emphasis added).

As this Court has recognized, at the very least, "considerable weight" should be accorded this administrative interpretation. *See Chevron*, 467 U.S. at 844. Indeed, in a statutory scheme as complex as the Medicaid Act, the Secretary's interpretation, based on longstanding expertise and explicit Congressional delegation, S. Rep. No.

1240, 94th Cong. 2d Sess., *reprinted in* 1976 U.S. Code & Admin. News 5648, 5649-51, should be given "legislative effect," and review of that interpretation by the courts should be limited to ensuring that the Secretary did not exceed his statutory authority and that the regulation is not arbitrary or capricious. *Schweiker*, 453 U.S. at 43.

Clearly, the Secretary's decision to require providers to challenge state provider payment decisions in state administrative proceedings must be given great deference, and this Court should not disturb the Secretary's longstanding interpretation of the Medicaid Act as it relates to the review of state provider payment decisions.

CONCLUSION

The lower courts have created, by implication from the Medicaid Act, enforceable rights for Medicaid providers. By allowing these rights to be enforced privately under § 1983 in a federal forum, the courts have restructured the national Medicaid program and disregarded Congressional intent that *states* devise individually-tailored reasonable payment plans rather than follow any express, mandatory system created by the Medicaid Act.

Congress deliberately did not create a specific enforceable right to any defineable level of payment on behalf of health care providers. The language and legislative history of the Medicaid Act clearly indicate that Congress intended two checks on state provider payment plans – review and approval by the Secretary and a state appeal process – but not federal, judicial interference.

To permit such judicial interference will upset the efficiency and workability of the system devised by Congress and ignore the fact that Congress struck a special balance between federal and state enforcement in creating and maintaining the unique Medicaid Program. The decisions of the courts below have upset and altered that balance. The Secretary's interpretation of program requirements reflecting this balance is entitled to deference.

For all of the reasons stated, the Commonwealth respectfully requests the Court to reverse the ruling of the Court of Appeals.

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